

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3331SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/20/2010
NAME OF PROVIDER OR SUPPLIER MOUNTAINVIEW HEALTH & REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 201 KOONTZ LANE CARSON CITY, NV 89701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	<p>Initial Comments</p> <p>Surveyor: 28626</p> <p>This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 1/20/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division, and in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing.</p> <p>Complaint #NV00024076 was unsubstantiated.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p>	Z 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE